2009 Medicare Managed Care Conference

Appeals and Grievances

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Session Topics

- Managed Care Appeals and Grievances
- Part C Medicare Advantage (MA)
- Part D Prescription Drug Plan (MA-PDP)

Definitions

- Grievance
- Organization Determination
- Appeal

Definitions

- Grievance
  - Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken.
  - An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.

Definitions

- Appeal
  - Procedures that deal with the review of adverse organization determinations by health care plans that an enrollee believes he or she is entitled to receive including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee),
  - When the enrollee is disputing the amount he/she must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the *Medicare health plan* and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

Organization Determinations

- Request for service or payment
- Denial of either may trigger the appeals process
- Appeals/reconsiderations are the same
- 5 levels of appeals

Organization Determination Time Frames

- Requests for Service -- As Expeditiously as Enrollee's Health Requires, NTE 14 Calendar Days

- Requests for Payment -- According to prompt payment provisions

Types of Appeals

Standard - Routine reconsideration of request for payment or service

Expedited - Requires quick answer to preserve life or functioning

Fast-Track – Quick decision about the end of services

Standard Review Process

Reconsideration Time Frames

- Requests for Service -- As Expeditiously as Enrollee's Health Requires, NTE 30 Calendar Days

- Requests for Payment -- NTE 60 Calendar Days

Expedited Review Process

Expedited Reconsiderations and Organization Determinations

- 72 Hour Process
- Oral Requests Permitted
- Service-related Requests Only
- Automatically Grant Physician Requests

MA Appeals Process

- MA Organization Reconsideration
- Independent Review Entity Reconsideration
- Administrative Law Judge Hearing
- Medicare Appeals Council Review
- Judicial Review

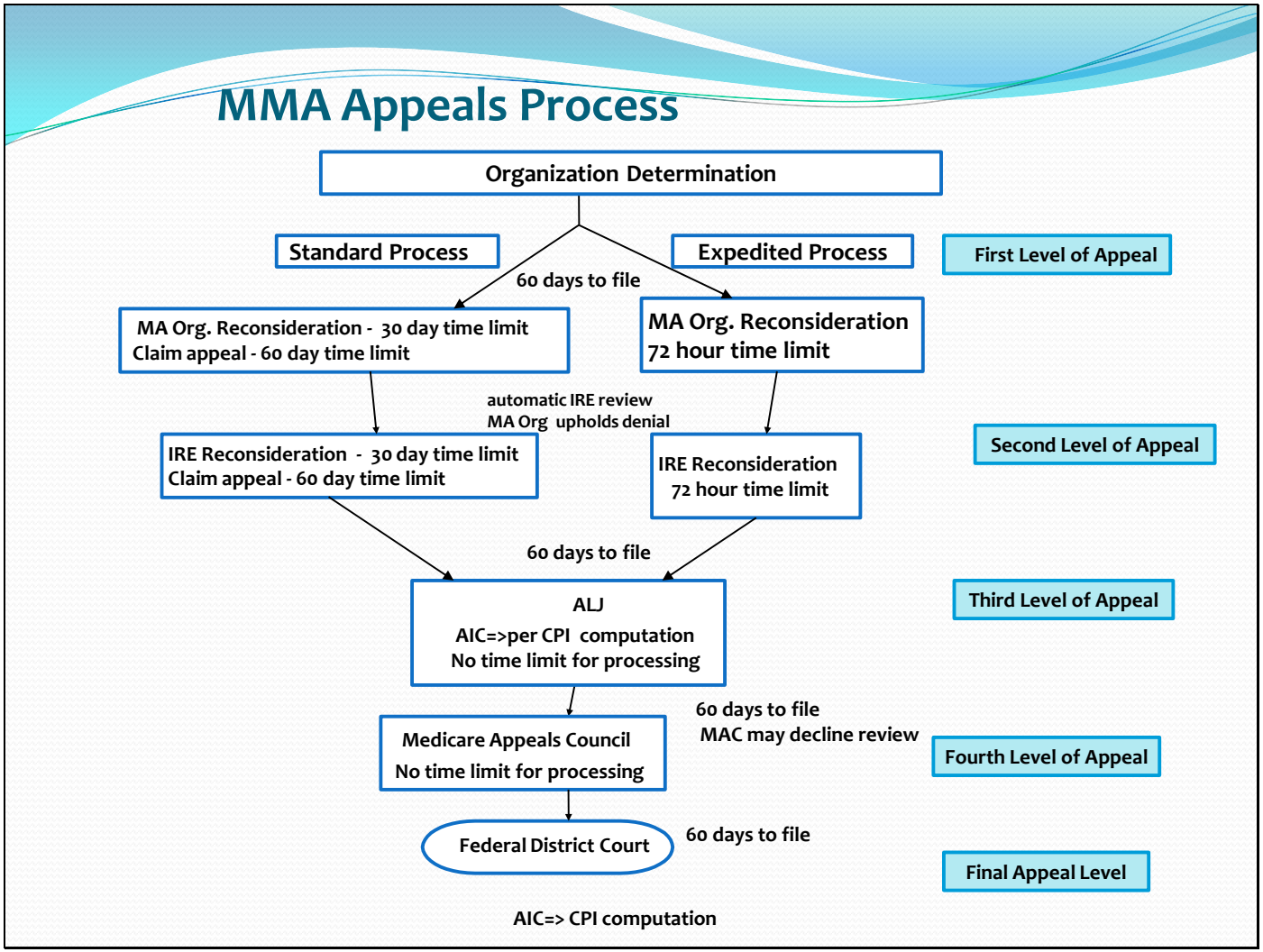
Independent Review Entities

- Center for Health Dispute Resolution (CHDR)

Automatic forward of MAO denials

- Quality Improvement Organizations (QIPRO)
- Administrative Law Judge (ALJ)
- Medicare Appeals Council (MACs)

MMA Appeals Process



Extensions: Standard & Expedited Time Frames

- Up to 14 Additional Calendar Days
- May be Requested by Enrollee
- MAO May Grant Itself an Extension

Non-Contracted Provider Appeals

- A non-contracted provider is permitted to file a standard appeal for a denied claim only if the provider completes a waiver of liability statement
- If the Medicare health plan does not receive the form by the conclusion of the appeal time frame, the Medicare health plan should forward the case to the independent review entity with a request for dismissal. The Medicare health plan must comply with the IRE's Reconsideration Process Manual section on reconsiderations that fail to meet the provider-as- a party requirements.

Session

- SNF, CORF, and HHA (MA)
- InPatient Hospital Discharge

Medicare Health Plan Fast-Track Appeals Process

- A patient's right when services are ending in a:
  - Skilled nursing facility
  - Home health agency
  - Comprehensive outpatient rehabilitation facility
- In patient Hospital Discharge

Appeals Notices

- Notice Of Denial Of Payment (NDP)
- Notice Of Denial Of Medical Coverage (NDMC)
- Important Notice from Medicare
- Notice Of Medicare Non-coverage (NOMNC)
- Detailed Explanation Of Non-coverage (DENC)
- ***Notice Of Discharge & Medicare Appeal Rights (NODMAR) (This form is no longer used)

Medicare Part D Prescription Drug Benefit

Part D Appeals Process Overview

Modeled after the Medicare Advantage program

- Grievances
- Initial Coverage Determination
- 5 Levels of Appeal
  - Redetermination by the Part D plan
  - Reconsideration by the Independent Review Entity
  - Hearing with an Administrative Law Judge
  - Review by the Medicare Appeals Council
  - Review by a Federal court

Differences Between Parts C and D

- Exceptions process
- Shorter adjudication timeframes
- Appeals are not automatically forwarded to the IRE

Shorter Adjudication Timeframes

	Standard	Expedited
Coverage determinations:	72 hours	24 hours
Redeterminations:	7 days	72 hours
Reconsiderations by IRE:	7 days	72 hours

Coverage Determinations and Appeals

- Involve the benefits an enrollee is entitled to receive or the amount, if any, that an enrollee is required to pay for a benefit.

- Include decisions concerning an exception to a plan's tiered cost-sharing structure or formulary.

Coverage Determinations: Exceptions

- Tiering Exceptions: Permit enrollees to obtain a non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier.

- Formulary Exceptions: Ensure that Part D enrollees have access to Part D drugs that are not included on a plan's formulary.

Approved Exceptions

- Valid for remainder of plan year, as long as
  - The enrollee continues to be a member of the plan
  - Physician continues to prescribe drug
  - Drug remains safe for treating the enrollee's condition
- Plan may extend coverage into the following plan year

Additional Safeguards

- Plans are prohibited from requiring additional exception requests for refills.
- Plans are prohibited from assigning drugs approved under the exceptions process to a special tier.
- Plans must notify enrollees in advance if they intend to change their formularies or cost-sharing structures during a plan year.

MA GRIEVANCES

THE PROCESS

- Every Health Plan Must Establish A Process For Hearing And Resolving Enrollee's Disputes timely , and Maintain Records On The Number of processed Grievances .
- All concerned parties must be notified expeditiously about the investigation results based on the enrollee's health status, but not later than 30 days after the grievance is received.

Grievance Requirements

The Medicare health plan must include in its grievance procedures:

- 60 Day time frame for member to submit grievance
- The ability to respond within 24 hours to an enrollee's expedited grievance whenever:
  - A Medicare health plan extends the time frame to make an organization determination or reconsideration; or
  - A Medicare health plan refuses to grant a request for an expedited organization determination or reconsideration.

Grievance
Part D Process

- An enrollee may file a grievance with the Part D plan sponsor either orally or in writing no later than 60 days after the event or incident that precipitates the grievance.

- Notification of investigation results to all concerned parties, as expeditiously as the enrollee's case requires, based on the enrollee's health status, no later than 30 days after the plan receives the oral or written grievance,

➢ May extend 14 days however the plan must notify the member in writing,

Grievance
Part D

- Any complaint or dispute, other than one that involves a coverage determination or an LIS or LEP determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Part D plan sponsor, regardless of whether remedial action is requested.

- A grievance may also include a complaint that a Part D plan sponsor refused to expedite a coverage determination or redetermination.

- Grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item.

Session

- More Information

MMA APPEALS & GRIEVANCE REFERENCES

- Title I MMA 42 CFR Subpart M 423.560-423.638
- Title II MMA 42 CFR Subpart M 422.560-422.626
- MMA Manual Chapter 13 MA Appeals & Grievances
- MMA Manual Chapter 18 Part D Grievances & Appeals

More Information

- FFS: Chapter 29 of the IOM 100-4 (Claims Processing)
- MA Appeals Webpage:
  - www.cms.hhs.gov/MMCAG
- BNI Webpage:
  - www.cms.hhs.gov/BNI
- Part D Appeals Webpage:
  - www.cms.hhs.gov/MedPrescriptDrugApplGriev
- Departmental Appeals Board:
  - www.hhs.gov/dab

More Information (continued)

- Independent Review Entity
  - www.medicareappeals.com (for MA)
  - www.medicarepartdappeals.com (for Part D)
- Office of Medicare Hearings and Appeals:
  - www.hhs.gov/omha
- Medicare.gov:
  - www.medicare.gov/Basics/appealsoverview.asp